

Private Health Insurance

What do I need to know about Private Health Insurance?

In today's complicated health care environment, finding your way through health insurance plans can seem overwhelming. Many families have access to health insurance as a part of the benefit package their employer offers, while others purchase health insurance on their own. Many of the 'mandates' for coverage issued by federal and state legislature are not equally applied to group and individual policies. As you seek to ensure your family's coverage needs are met, it is important to learn about the types of insurance plans, their limits, and the policyowner's rights.

Types of Health Insurance

Each year fewer Hoosiers are covered under fee-for-service health insurance plans in which insured individuals go to a doctor of their choosing and then submit their own health insurance claims. Today more Americans are covered by one of the following arrangements:

Preferred Provider Organization (PPO). A PPO is a network of doctors and hospitals that have agreed to a discounted amount in exchange for direct reimbursement from an insurance company or administrator. This network of providers is offered through a health plan either on a group or individual basis. Typically, there are deductibles and co-insurance amounts as part of the benefit plan design. Services can be provided by non-contracted providers; however, a higher copayment and deductible amount is usually associated with out-of-network services.

Health Maintenance Organization (HMO). An HMO is a form of managed care in which services are provided through a restricted network of providers. Enrollment in an HMO requires the selection of a primary care physician (family doctor) who may refer to specialists for health services. HMOs may also offer a Point of Service (POS) option, which allows more flexibility when choosing a physician. The POS option may not require referrals for specialty care. The POS option is generally more expensive and may require higher copays and deductibles.

Individual/ Family plans. Another option for families is to buy their own health insurance. There are many plan designs to choose from with varying deductibles, co-pays, and co-insurance amounts. The Patient Protection and Affordable Care Act made it easier to compare and purchase health insurance plans. Individuals wishing to purchase plans may visit www.healthcare.gov to view the plan options, speak with an insurance agent, or speak with a local navigator: <https://in-fssa.force.com/HCNav/>

Health Savings Accounts (HSA). Health Savings Accounts are used together with a qualified High Deductible Health Plan (HDHP). These types of plans are becoming more popular with employers and individuals as the monthly cost is typically less than that of a PPO plan due to the higher deductible. Families can put money into the HSA on a pre-tax basis, and any unused money rolls over from year to year. Employers may offer the choice of a PPO plan and a HDHP plan and the cost differences can be significant. Many people choose to select the HDHP plan and put the difference in cost into their HSA account. For those with Medicaid, HSAs are exempt as a resource if the account is restricted to use for qualified medical expenses only (this may require verification to determine if the account can be used for purposes other than qualified medical expenses).

Self-Funded versus Fully Insured: Understanding the difference

There are two ways an employer can structure a group health plan: self-funded or fully-insured. Self-funded plans use the employer's money to pay medical claims.

Employers contract with an administrator, perhaps an insurance company, to process and pay claims with the employer's money. In contrast, fully insured plans use the insurance company's money to pay claims. Employees typically contribute towards the premium regardless of which type of plan they have. It is important to know which plan you have because only insured and individual/family plans are regulated by the state's Department of Insurance. Self-Funded plans fall under federal law and do not have to follow state-mandated benefits. Your employer can tell you which type of plan you have. It is also important to know that if your employer is not based in Indiana, your health insurance mandates will be governed by that state's laws and NOT Indiana's mandates.

Flexible Spending Accounts:

A flexible spending account (or flex account) is offered as an option, often in addition to insurance, through some employers. A flex account allows an employee to set aside a portion of their earnings to pay for qualified expenses (defined by the IRS), such as medical expenses and dependent care expenses. Money deducted from an employee's pay into a flex account is pre-tax money. These plans can provide an important tax benefit for some families. When evaluating this type of plan, carefully consider what expenses are allowable and how much money will be used in a year. *Generally, money not spent during the designated year is lost, however some employers provide a "grace period".*

For More Information about Insurance Plans and Benefits:

Insurance plans come with materials that explain benefits, procedures for obtaining authorization of services, and addressing appeals and concerns. Employers, human resources departments, and plan administrators are key sources for this type of information and may share it electronically. Additionally, the Patient Protection and Affordable Care Act added consumer protections, including out of pocket limits and additional services that apply to certain plans. [Covering Kids & Families of Indiana](#) can help you understand coverage, including rules and benefits.

Who to contact with complaints:

When you have a complaint, be sure to review your policy booklet to ensure the service in question is covered and proper pre-certification, network use and claim submission guidelines have been followed. Families should keep a copy of all bills, claims and other documentation to assist in the resolution of any issues. If a claim is denied, the reason should be stated on the explanation of benefits. If there is a disagreement with the denial, check your policy or employee booklet for the company's appeal procedures. The company should be able to answer procedural questions about appeals over the phone. Any appeal should be in writing and may require further information.

Families who have tried unsuccessfully to resolve a claim issue and who have a plan that is self-funded can take unresolved complaints to the U.S. Department of Labor (DOL) Employee Benefits Security Administration. In Northern Indiana, call: 1-312-353-0900. In Southern Indiana, call 1-859-578-4680, <https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices>

If your family health plan is fully insured or an individual/family plan, contact the Indiana Department of Insurance, Consumer Services Division at 1-800-622-4461. Complaint forms and additional consumer information are available on the Department's web site: <https://www.in.gov/idoi/consumer-services/>.

Programs and systems change often. It is important to ensure that you are using the most current information. This fact sheet was updated February 2025. Please check <https://www.inf2f.org/fact-sheets.html> for the most recent edition.

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